THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE WORKERS' COMPENSATION ACT

## NORTH CAROLINA INDUSTRIAL COMMISSION RALEIGH

## DENTISTS ITEMIZED STATEMENT OF CHARGE FOR TREATMENT and

## CERTIFICATION OF TREATMENT OF DISABILITY

Code numbers assigned to each employer and carrier should be inserted before mailing.

			Employer:19Nature of Injury								
Date of Accid	lent: 		19	Nature of	Injury						
		 Examination	n and treatment plan - List in	order from tooth no. 1	through to	ooth n	n 32 :	Use chartin	r system s	shown.	
	Tooth # or letter	<del></del>	Description of service (including x-rays, prophylaxi Line No.		Da	Date service performed Mo. Day Year			Procedure Fees		For administrativ use only
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TE MISSING TEETH WITH AN ''X''			14			1				1	
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OR UNUSUAL SERVICES									<del></del>	_	
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			pe of crowns, descrption of dicate on chart the work pe		of partia	ls.		ĺ	TOT	`AL	
Please refer to N.	C.I.C. m	edical fee	e schedule for C. P. T. codes		gery perf	ormed	l.	<u> </u>	101		
			•	s for x-rays and sur							
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Bill for Dental Services Must be Presented in Duplicate on This Form. Be Specific. No Other bill Services is Required. Give Full Explanation of Any Charges in Excess of Published Fee Schedule.